CHOICES FOR MEDICARE ADVANTAGE

The Medicare Modernization Act (MMA) expands the existing options available to Medicare beneficiaries to enroll in private health plans. Currently, about 4.8 million beneficiaries are enrolled Medicare Advantage plans. The Medicare Advantage plans, which include both coordinated care plans and private fee-for-service plans, generally provide more benefits at a lower cost to beneficiaries. The MMA expanded the program with the establishment of a new regional contracting option for health plans, called Medicare Advantage regional plans. Local Medicare Advantage plans serve individual counties and groups of counties, whereas regional PPOs will bid to serve an entire region - which may be a state or multi-state area. Both local and regional plans must provide all original Medicare benefits.

New Regional PPOs

The new regional plans, which are authorized beginning in 2006 and are structured as preferred provider organizations (PPOs). These plans have a network of doctors and hospitals that contractually agree to provide health care services at a specified rate, but which also allow enrollees to go outside the network for care, usually for an additional charge. PPOs are now the most popular type of coverage in the private market in the U.S. In 2002, 52 percent of Americans covered under group health insurance programs were enrolled in PPOs. Medicare Advantage regional plans may also operate in more than one region, or even nationally. On December 6, the Secretary announced 26 Medicare Advantage regions. The regions were configured to maximize plan participation and beneficiary choice.

In response to comments received on the proposed rules, CMS has done everything possible in the final rule to ensure that MA regional plans that participate in Medicare will closely resemble PPO products already available in the non-Medicare market, including the Federal Employees Health Benefit Program. In this way, CMS intends to ensure that Medicare beneficiaries are offered a robust number of choices from which they can receive their Medicare and prescription drug benefits.

Changes in funding designed to stabilize the Medicare Advantage program, in addition to special financial incentives for Medicare Advantage regional plans in the initial years of the program, should make more Medicare Advantage options available to more Medicare beneficiaries. This is already happening: even ahead of the regional plan availability in 2006, many Medicare Advantage plans are expanding service areas and benefits as a result of the more secure payments. Beneficiaries will receive materials each Fall that outline the options available to them and direct them to sources for additional information, enabling them to take the greatest advantage of the coverage available in Medicare.

Also addressed in the final regulation is a new option created by the MMA for specialized plans for Medicare beneficiaries who have special needs, such as the institutionalized, those with Medicaid, and individuals with severe or disabling chronic conditions.

Local Medicare Advantage Plans

The MMA allows for three categories of local Medicare Advantage plans:

- **Coordinated Care Plans:** These include health maintenance organizations (HMOs), with and without Point-of-Service (POS) options, and Preferred Provider Organization (PPO) plans. About 4,755,000 Medicare beneficiaries are enrolled in these coordinated care plans.

- **Private Fee-For-Service Plans:** This plan option is offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the Private Fee-For-Service (FFS) organization to arrange for health care coverage for Medicare beneficiaries who have enrolled in the Private FFS plan. About 58,000 Medicare beneficiaries are enrolled in private FFS plans.

- **Medical Savings Account (MSA) Plans:** Under this option, the beneficiary chooses a qualifying Medicare MSA high-deductible insurance plan. Medicare then pays the premium for the MSA plan and generally makes a deposit into the Medicare MSA that is established by the beneficiary. The beneficiary uses the money in the Medicare MSA to pay for services provided before the deductible is met, and for other health care services not covered by the MSA plan. Any remaining funds are allowed to accrue from year-to-year. The MSA option is similar to the health savings accounts (HSAs) the MMA made available for the non-Medicare population. These products are designed to allow participants to play a greater role in their health care purchasing decisions. As more beneficiaries enter Medicare with HSAs, this option will allow them to continue to support their account.

  Currently, no MSA plans are contracting with Medicare. Prior to the MMA, the MSA program was a time-limited demonstration with a limit on the number of enrollees. The MMA made the MSA program a permanent option for beneficiaries without a limit on enrollment. By eliminating the limit on enrollees and the enrollment deadline, the MMA makes this option more attractive for plans and beneficiaries.

Benefits

Both local and regional Medicare Advantage plans must provide all Medicare-covered benefits. Medicare Advantage plans generally provide Medicare benefits at a much lower cost to beneficiaries and they also provide non-Medicare benefits that enhance and improve upon the Medicare package. Examples of these improved benefits include preventive care, disease management for chronic illnesses, dental and vision care, and other services. Medicare Advantage plans have been preferred by millions of seniors because they offer lower costs (overall savings for the Medicare and non-Medicare benefits of over $700 per year in out-of-pocket costs for the average beneficiary and nearly $2,000 in savings for those beneficiaries in poor health) compared to traditional Medicare for beneficiaries who do not have supplemental coverage from an employer or Medicaid. With regard to Medicare-covered benefits and the out-of-pocket costs that individuals typically have for such benefits, savings in Medicare Advantage are increasing with an average of $34 in out-of-pocket costs per month for covered services in 2005 for MA enrollees, as compared to an average of $119 in monthly out-of-pocket costs for FFS.

Most Medicare Advantage plans require enrollees to use network providers for care to be covered by the plan (except in emergencies). Beneficiaries in a Medicare Advantage regional plan will typically have lower out-of-pocket costs when they remain in-network, though the regional PPOs will provide coverage for out-of-network services. As a result, beneficiaries in regional PPOs can get access to cost-saving advantages like those in a local Medicare Advantage plan, but they can also get coverage for any provider they wish to use, even in a non-emergency situation.

Unlike traditional fee-for-service Medicare with its separate deductibles for Parts A and B, regional Medicare Advantage plans that have deductibles in their benefits design must have a single, unified deductible. They may waive the deductible for preventive services and other services. Regional Medicare Advantage plans must also have catastrophic limits on out-of-pocket expenses for in-network Medicare services and for all Medicare services. Some local plans may have a single deductible or catastrophic limit on enrollee out-of-pocket costs, but they are not required to do so.

Medicare Advantage and AI/AN beneficiaries

CMS will be working with the Tribal Technical Advisory Group and Indian Health Service to develop information related to Medicare Advantage and opportunities available to Indian Health Care Providers.